DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICAID AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: TN 03-017

2. STATE: Ohio

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 12, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a)(13)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ -0-
b. FFY 2004 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D rules:

5101:3-3-20, 5101:3-3-20.2, 5101:3-3-26, 5101:3-3-43, 5101:3-3-49, 5101:3-3-50.1, 5101:3-3-53, 5101:3-3-56, 5101:3-3-78, 5101:3-3-82, 5101:3-3-83.1, 5101:3-3-84.4, 5101:3-3-86, and 5101:3-3-89.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D rules:
5101:3-3-20, 5101:3-3-20.2, 5101:3-3-26, 5101:3-3-43, 5101:3-3-49, 5101:3-3-50.1, 5101:3-3-53, 5101:3-3-56, 5101:3-3-78, 5101:3-3-82, 5101:3-3-83.1, 5101:3-3-84.4, 5101:3-3-86, and 5101:3-3-89. (Delete rule 5101:3-3-24.2 from Attachment 4.19D)

10. SUBJECT OF AMENDMENT:
These rules were implemented as an integral part of the rule review provisions set forth under Ohio Revised Code Section 119.032.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
x OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Thomas J. Hayes

14. TITLE:
Director

15. DATE SUBMITTED:
September 25, 2003

16. RETURN TO:
Becky Jackson
Bureau of Health Plan Policy
Ohio Department of Job and Family Services
30 East Broad Street, 27th floor
Columbus, Ohio 43215-3414

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 26 2003

18. DATE APPROVED: APR - 5 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP 12 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Barrie for Smit

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

5101:3-3-20 **Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements.**

As a condition of participation in the Title XIX medicaid program, each nursing facility (NF) and intermediate care facility for the mentally retarded (ICFs-MR) shall file a cost report with the Ohio department of ~~human services (ODHS)~~job and family services (ODJFS). The cost report, [~~ODHS 2524~~JFS 02524-appendix ~~a~~A of rule 5101:3-3-202 of the Administrative Code] including its supplements and attachments as specified under paragraphs (A) to (M) of this rule or other approved forms for state-operated ICFs-MR, must be filed within ninety days after the end of the reporting period. Except as specified under paragraph (F) of this rule, the report shall cover a calendar year or the portion of a calendar year during which the NF or ICF-MR participated in the medical assistance program. In the case of a NF or ICF-MR that has a change of provider agreement, as defined in rule ~~5101:3-3-516~~51013-3-51.6 or ~~5101:3-3-845~~5101:3-3-84.5 of the Administrative Code, during a calendar year, the report by the new provider shall cover the portion of the calendar year following the change of provider agreement encompassed by the first day of participation up to and including December thirty-first, except as specified under paragraph (H) of this rule. In the case of a NF or ICF-MR that begins participation after January first and cases participation before December thirty-first of the same calendar year, the reporting period shall be the first day of participation to the last day of participation. ODHS shall issue the appropriate software and an approved list of vendors for an electronically submitted cost report no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state-operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in rule ~~5101:3-3-201~~5101:3-3-20.1 of the Administrative Code, or relate its chart of accounts directly to the cost report.

(A) For fiscal years beginning on and after July 1, 1996, first of each fiscal year the prospective rate shall be based on the calendar year ending December thirty-first cost report that precedes the fiscal year in which the rate is paid, except as specified under paragraph (H) of this rule. Cost reports, filed by NFs and ICFs-MR, for these periods, shall be filed on an electronic basis.

(B) For good cause, as deemed appropriate by ~~ODHS~~ODJFS, cost reports may be submitted within fourteen days after the original due date if written approval from ~~ODHS~~ODJFS is received prior to the original due date of the cost report. Requests for extensions must be in writing which explain the circumstances beyond the control of the provider such as loss of accounting records through acts of God or loss of the cost report preparer within thirty days of the cost report due date. Cost report extensions will not be granted for corporate reorganizations or vague explanations.

(1) For purposes of this rule, "original due date" means each facility's cost report is due ninety days after the end of each facility's reporting period. Unless waived by ~~ODHS~~ODJFS, the reporting period ends as follows:

(a) On the last day of the calendar year for the health care facility's year end cost report, except as provided in a paragraph (H)(2) of this rule; or

(b) On the last day of medicaid participation at the old facility or when it closes to relocate to a new facility or to alter the existing facility; or

(c) On the last day before a change of provider agreement as defined in rules ~~5101:3-3-516~~5101:3-3-51.6 and ~~5101:3-3-845~~5101:3-3-84.5 of the Administrative Code.

(d) On the last day of the new facility's or new provider's first three full calendar months of participation under the medical assistance program which encompasses the first day of medicaid participation.

(2) If a facility does not submit the cost report within fourteen days after the original due date, or by the extension date granted by ~~ODHS~~ODJFS or submits an incomplete or inadequate report, ~~ODHS~~ODJFS shall provide immediate written notice to the facility that its provider agreement will be terminated in thirty days unless the facility submits a complete and adequate cost report within thirty days of receiving the notice.

(3) For each day the cost report is submitted after its original due date, the provider shall be assessed a late file penalty. The late file penalty shall be determined using the prorated medicaid days paid in the late file period multiplied by the penalty. The penalty shall be two dollars per patient day adjusted each July first for inflation during the preceding twelve months as stated in ~~the "Consumer Price Index for All Items for All Urban Consumers for the North Central Region" published by the United States department of labor~~division (A)(2) of section 5111.26 of the Revised Code. The late file period will begin the day after the cost report's due date and continue until the cost report is received by the Ohio department of ~~human services~~job and family services or the facility is terminated from the medicaid program. The late file penalty shall be a reduction to the medicaid vendor payment. No penalty shall be imposed during a fourteen-day extension granted by ~~ODHS~~ODJFS as specified in paragraph (E) of this rule.

(C) An "Addendum for Disputed Costs" shall be an attachment to the cost report that a NF or ICF-MR may use to set forth costs the facility believes may be disputed by ~~ODHS~~ODJFS. The costs stated on the addendum schedule are to have been applied to the other schedules or attachments as instructed by the cost report and/or chart of accounts for the cost report period in question (either in the reimbursable or the nonreimbursable cost centers). Any costs reported by the facility on the addendum

may be considered by ~~ODHS~~ODJFS in establishing the facility's prospective rate. If ~~ODHS~~ODJFS does not consider the costs listed on the addendum in calculating the facility's rate, the facility may seek reconsideration of that determination under rule 5101:3-3-24 of the Administrative Code. If ~~ODHS~~ODJFS determines as a result of the reconsideration, the rate established for the facility is less than the rate to which it is entitled, ~~ODHS~~ODJFS shall increase the rate. If ~~ODHS~~ODJFS has paid the incorrect rate, the facility shall be paid the difference between the amount it was paid for the period and the amount it should have been paid with interest. Interest shall be determined accordingly:

(1) The rate of interest shall be the rate in effect on the last day of the period affected by the incorrect rate. The rate of interest shall be based on the average bank prime rate.

(2) ~~ODHS~~ODJFS shall determine the average bank prime rate using statistical release H.15, "Selected interest rates", a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15 or its successor, ceases to contain the bank prime rate information or ceases to be published, ~~ODHS~~ODJFS shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

(3) Interest payments shall be calculated on the basis of simple interest.

(D) ~~ODHS~~ODJFS shall conduct a desk review of each cost report it receives. Based on the desk review, the department shall make a preliminary determination of whether the reported cost are allowable costs. Before issuing the determination ~~ODHS~~ODJFS shall notify the facility of any information on the cost report that requires further support. The facility shall provide any documentation or other information requested by ~~ODHS~~ODJFS and may submit any information that it believes supports the reported costs. ~~ODHS~~ODJFS shall notify each NF and ICF-MR of the following: whether any of its costs are preliminarily determined not to be allowable and the reasons for the determination and the resulting rate as determined under Chapter 5101:3-3 of the Administrative Code.

(1) A desk review of cost reports filed for each period is conducted to ensure mathematical correctness and that the rate setting calculations are consistent with the rate setting formula contained in Chapter 5101:3-3 of the Administrative Code. Also, a desk review is conducted to identify categories of reported costs materially exceeding peer group averages or the provider's historical filed cost trends as determined by ~~ODHS~~ODJFS, that require further verification. Following the desk review, and the acceptance of the cost report, cost report data is used to determine the prospective rate setting.

(2) A facility may revise the cost report within sixty days after the original due date without the revised information being considered an amended cost report.

(3) The cost report is considered accepted after the cost report has passed the desk review process.

(4) After final rates have been issued, a provider who disagrees with a desk review decision may request a rate reconsideration, as specified in rule 5101:3-3-24 of the Administrative Code.

(E) During the time when a cost report is open for audit as defined in rule 5101:3-3-21 of the Administrative Code, the provider may amend the cost report upon discovery of a material error or additional information that increases or decreases the total payment rate by ten cents per patient day or greater. If the error or additional information would change the payment rate by less than ten cents per patient day, the provider may not, amend the cost report. ~~ODHS~~ODJFS shall not charge interest under division (B) of section 5111.28 of the Revised Code based on any error or additional information that is not required to be reported under this paragraph. ~~ODHS~~ODJFS shall review the amended cost report for accuracy and notify the provider of its determination. Since the audit determines reasonable and allowable costs, a cost report cannot be amended once an audit has been completed. However, should subsequent events occur or information become available to the provider after the audit is completed that affects the costs for the cost-reporting period, such information may be submitted to ~~ODHS~~ODJFS if the final settlement of the cost report period has not been adjudicated.

(F) The annual cost report submitted by state-operated facilities shall cover the twelve-month period ending June thirtieth of the preceding year, or portion thereof, if medicaid participation was less than twelve months.

(G) Cost reports submitted by county and state-operated facilities may be completed on accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.

(H) Three-month cost reports:

(1) Facilities new to the medical assistance program that are subject to the provisions of rules 5101:3-3-53 and 5101:3-3-86 of the Administrative Code shall submit a cost report pursuant to paragraph (B)(1) of this rule for the period which includes the date of certification and subsequent three full calendar months of operations. The new provider of a facility that has a change of provider agreement, as defined in rule ~~5101:3-3-516~~5101:3-3-51.6

or ~~5101:3-3-845~~1101:3-3-84.5 of the Administrative Code, on or after the effective date of this amendment shall submit a cost report within ninety days after the end of the facility's first three full calendar months after the change of provider agreement.

(2) If a facility described in paragraph (H)(1) of this rule opens or changes provider agreement on or after October second, the facility is not required to submit a year end cost report for that calendar year.

(I) Providers are required to identify all known related organizations as set forth under paragraph (BB) of rule 5101:3-3-01 of the Administrative Code.

(J) Providers are required to identify all of the following:

(1) Each known individual, group of individuals, or organization not otherwise publicly disclosed who owns or has common ownership as set forth under paragraphs (BB) and (CC) of rule 5101:3-3-01 of the Administrative Code, in whole or in part, any mortgage, deed of trust, property or asset of the facility. When the facility or the common owner is a publicly owned and traded corporation, this information beyond basic identifying criteria is not required as part of the cost report but must be available within two weeks when requested. Publicly disclosed information must be available at the time of the audit; and

(2) Each corporate officer or director, if the facility is a corporation; and

(3) Each partner, if the facility is a partnership; and

(4) Each facility, whether participating in the medicare or medicaid program or not, which is part of an organization which is owned, or through any other device controlled, by the organization of which the provider is a part; and

(5) Any director, officer, manager, employee, individual, or organization having direct or indirect ownership or control of five per cent or more [see paragraph (I) of this rule], or who has been convicted of or pleaded guilty to a civil or criminal offense related to his involvement in programs established by Title XVIII (medicare), Title XIX (medicaid), or Title XX (social services) of the social security act, as amended; and

(6) Any individual currently employed by or under contract with the provider, or related party organization, as defined under paragraph (I) of this rule, in a managerial, accounting, auditing, legal, or similar capacity who was

employed by ~~ODHS~~ODJFS, the Ohio department of health, the office of attorney general, the Ohio department of aging, the Ohio department of mental retardation and developmental disabilities, or the Ohio department of industrial relations within the previous twelve months.

(K) Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is twenty-five thousand dollars or more in a twelve-month period; or for the services of a sole ~~proprietor~~proprietor or partnership where there is no cost incurred and the imputed value of the service is twenty-five thousand dollars or more in a twelve-month period, the audit provisions of 42 C.F.R. 420 subpart (D) (effective 12/30/82), apply to these contractors.

(1) For purposes of this rule, "contract for service" is defined as the component of a contract that details services provided; exclusive of supplies and equipment. It includes any contract which details services, supplies; and equipment to the extent the value of the service component is twenty-five thousand dollars or more within a twelve-month period.

(2) For purposes of this rule, "subcontractor" is defined as any entity, including an individual or individuals, who contract with a provider to supply a service, either to the provider or directly to the beneficiary, where medicaid reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is twenty-five thousand dollars or more in a twelve-month period.

(L) Financial, statistical and medical records (which shall be available to ODHS and to the U.S. department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ~~ODHS~~ODJFS issues an audit report in accordance with rule 5101:3-3-21 of the Administrative Code, or six years after all appeal rights relating to the audit report are exhausted.

(1) Failure to retain the required financial, statistical, or medical records, renders the provider liable for monetary damages of the greater amount:

(a) One thousand dollars per audit; or

(b) Twenty-five per cent of the amount by which the undocumented cost increased the medicaid payments to the provider, during the fiscal year.

(2) Failure to retain the required financial, statistical, or medical records to the extent that filed cost reports are unauditable shall result in the penalty as specified in paragraph (L)(1) of this rule. Providers whose records have been found to be unauditable will be allowed sixty days to provide the necessary documentation. If, at the end of the sixty days, the required records have been provided and are determined auditable, the proposed penalty will be withdrawn. If ~~ODHS~~ODJFS, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditable, ~~ODHS~~ODJFS shall impose the penalty as specified in paragraph (L)(1) of this rule.

(3) Refusing legal access to financial, statistical, or medical records shall result in a penalty as specified in paragraph (L)(1) of this rule for outstanding medical services until such time as the requested information is made available to ~~ODHS~~ODJFS.

(4) All requested financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents shall be available at a location in the state of Ohio for facilities certified for participation in the medicaid program by this state within at least sixty days after request by the state or its subcontractors. The preferred Ohio location is the facility itself, but may be a corporate office, an accountant's office, or an attorney's office elsewhere in Ohio. This requirement, however, does not preclude the state or its subcontractors from the option of conducting the audit and/or a review at the site of such records if outside of Ohio.

(M) When completing cost reports, the following guidelines shall be used to properly classify costs:

(1) All depreciable equipment valued at five hundred dollars or more per item and a useful life of at least two years or more, is to be reported in the capital cost component set forth under rules 5101:3-3-51 and 5101:3-3-84 of the Administrative Code. The costs of equipment acquired by an operating lease, including vehicles, executed before December 1, 1992, may be reported in the indirect care cost component if the costs were reported as administrative and general costs on the facility's cost report for the reporting period ending December 31, 1992, until the current lease term expires. The costs of any equipment leases executed before December 1, 1992 and reported as capital costs, shall continue to be reported under the capital cost component. The costs of any new leases for equipment executed on or after December 1, 1992, shall be reported under the capital costs component. Operating lease costs for equipment, which result from extended leases under the provision of a lease option negotiated on or after December 1, 1992, shall be reported

under the capital cost component.

(2) Except for employers' share of payroll taxes, workers compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost centers shall not be allowed. Wages and benefits for staff including related parties who perform duties directly related to functions performed in more than one cost center which would be expended under separate cost centers if performed by separate staff may be expended to separate cost centers based upon documented hours worked, provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to bathing and dressing chores in the early hours but works in the kitchen as a dietary aide for the remainder of the shift may be expended to separate cost centers provided the facility maintains adequate documentation of hours worked in each cost center.

(3) The costs of resident transport vehicles are reported under the capital cost component set forth under rules 5101:3-3-51 and 5101:3-3-84 of the Administrative Code. Maintenance and repairs of these vehicles is reported under the indirect care cost component.

Effective: 09/12/2003

R.C. 119.032 review dates: 06/25/2003 and 09/12/2008

CERTIFIED ELECTRONICALLY

Certification

09/02/2003

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.26
Prior Effective Dates: 12/30/77, 12/17/98